

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PDC #1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445124		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2017	
NAME OF PROVIDER OR SUPPLIER THE WATERS OF GALLATIN, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 555 EAST BLEDSOE STREET GALLATIN, TN 37066			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	INITIAL COMMENTS			F 000			
F 278 SS=D	<p>A recertification survey and complaint investigation #40360, #41301, #41529, #41809, #41885 and #42449 were completed on 10/9/17-10/11/17 at The Waters of Gallatin. Deficiencies were cited related to the recertification survey and complaint investigation #41809 and #41885, under 42 CFR PART 483, Requirements for Long Term Care Facilities.</p> <p>483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.</p> <p>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p>			F 278	<p>1. Resident #34 was scheduled and assessed by the Dentist on 10/13/2017 with no immediate action required. Care plan was updated by the Minimum Data Set Nurse (MDS) on 10/13/17. The Minimum Data Set (MDS) Nurses were trained on Section L, "Oral/Dental Status", on 10/24/17 by the Regional MDS Registered Nurse. MDS Nurse on (10/27/17) opened a Significant Change MDS for Resident #34 to include the corrected coding for Section L to reflect Resident #34 current dental status. The Quarterly MDS's dated 2/7/17, and 8/2/17 required no changes in coding as the Quarterly MDS only addresses dentures and Resident #34 does not have dentures.</p> <p>2. All Residents have the potential to be affected by this practice. Oral Assessments were completed on residents by the Licensed MDS Nurses and completed on 10/20/17. Any residents who were identified with oral or dental concerns were referred to the physician and dental appointments scheduled for follow up. Responsible parties were notified and Care plans will be updated as needed.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Robin Williams

Administrator

10.30.2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	<p>Continued From page 1</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accurately assess the oral status of 1 resident (#34) of 20 residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #34 was admitted to the facility on 3/31/09 and readmitted on 9/8/09 and 11/9/15 with diagnoses including Alzheimer's Disease, Abnormal Posture, Urinary Tract Infection, Autonomic Neuropathy in Diseases, Restless Legs Syndrome, Vitamin D Deficiency, Acquired Hemolytic Anemia, Anxiety Disorder, Major Depressive Disorder, Dementia without Behavioral Disturbance and Hypertension.</p> <p>Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/7/17, the Annual MDS dated 5/5/17, and the Quarterly MDS dated 8/2/17 of the Oral/Dental Status section revealed the resident had no concerns.</p> <p>Observation on 10/10/17 at 9:53 AM in the Main Dining Room, on 10/10/17 at 12:40 PM in the 600 Hall area, and on 10/11/17 at 7:20 AM in the 600 Hall dining area revealed Resident #34 had several missing front teeth at the top and bottom of the mouth.</p>	F 278	<p>3. MDS Nurses were trained by the Regional MDS Nurse on Section L, "Oral/Dental Status", on 10/24/17. The MDS Consultant will Audit 10% of Comprehensive MDS Assessments monthly for 3 months to ensure accurate coding effective 10/25/17. Any concerns identified will be immediately addressed with reeducation, correction and communicated to the Administrator.</p> <p>4. The MDS Consultant will Audit 10% of Comprehensive MDS Assessments monthly for 3 months to ensure accurate coding by comparison of resident observation. Any concerns identified will be immediately addressed with reeducation, correction and communicated to the Administrator. The results of audits will be forwarded to the Administrator and Director of Nursing for review then forwarded to the QAPI Committee for review and recommendations.</p>		10.24. 2017

Date:

Subjects covered:

Inservice Provided by: Kerrigan, RN, Regional

PRINT NAME

Betty Lock

SIGNATURE

SIGNATURE
Butte Lock

TITLE

Ans

SHIFT

8-4

Phone Call to
Danielle Gatchel

For this is S. V. A.

1 Betty Lou R.

SECTION L: ORAL/DENTAL STATUS

Intent: This item is intended to record any dental problems present in the 7-day look-back period.

L0200: Dental

L0200: Dental	
↓ Check all that apply	
<input type="checkbox"/>	A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)
<input type="checkbox"/>	B. No natural teeth or tooth fragment(s) (edentulous)
<input type="checkbox"/>	C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn)
<input type="checkbox"/>	D. Obvious or likely cavity or broken natural teeth
<input type="checkbox"/>	E. Inflamed or bleeding gums or loose natural teeth
<input type="checkbox"/>	F. Mouth or facial pain, discomfort or difficulty with chewing
<input type="checkbox"/>	G. Unable to examine
<input type="checkbox"/>	Z. None of the above were present

Item Rationale

Health-related Quality of Life

- Poor oral health has a negative impact on:
 - quality of life
 - overall health
 - nutritional status
- Assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

Planning for Care

- Assessing dental status can help identify residents who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

DEFINITIONS

CAVITY

A tooth with a discolored hole or area of decay that may have debris in it.

BROKEN NATURAL TEETH OR TOOTH FRAGMENT

Very large cavity, tooth broken off or decayed to gum line, or broken teeth (from a fall or trauma).

ORAL LESIONS

A discolored area of tissue (red, white, yellow, or darkened) on the lips, gums, tongue, palate, cheek lining, or throat.

EDENTULOUS

Having no natural permanent teeth in the mouth.
Complete tooth loss.

L0200: Dental (cont.)

Steps for Assessment

1. Ask the resident about the presence of chewing problems or mouth or facial pain/discomfort.
2. Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.)
3. If the resident has dentures or partials, examine for loose fit. Ask him or her to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment.
4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth.
5. If the resident is unable to self-report, then observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present.
6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues.

DEFINITIONS**ORAL MASS**

A swollen or raised lump, bump, or nodule on any oral surface. May be hard or soft, and with or without pain.

ULCER

Mouth sore, blister or eroded area of tissue on any oral surface.

Coding Instructions

- **Check L0200A, broken or loosely fitting full or partial denture:** if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk.
- **Check L0200B, no natural teeth or tooth fragment(s) (edentulous):** if the resident is edentulous/lacks all natural teeth or parts of teeth.
- **Check L0200C, abnormal mouth tissue (ulcers, masses, oral lesions):** select if any ulcer, mass, or oral lesion is noted on any oral surface.
- **Check L0200D, obvious or likely cavity or broken natural teeth:** if any cavity or broken tooth is seen.
- **Check L0200E, inflamed or bleeding gums or loose natural teeth:** if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip.
- **Check L0200F, mouth or facial pain or discomfort with chewing:** if the resident reports any pain in the mouth or face, or discomfort with chewing.
- **Check L0200G, unable to examine:** if the resident's mouth cannot be examined.
- **Check L0200Z, none of the above:** if none of conditions A through F is present.

L0200: Dental (cont.)

Coding Tips

- Mouth or facial pain coded for this item should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met.
- The dental status for a resident who has some, but not all, of his/her natural teeth that do not appear damaged (e.g., are not broken, loose, with obvious or likely cavity) and who does not have any other conditions in L0200A–G, should be coded in L0200Z, none of the above.
- Many residents have dentures or partials that fit well and work properly. However, for individualized care planning purposes, consideration should be taken for these residents to make sure that they are in possession of their dentures or partials and that they are being utilized properly for meals, snacks, medication pass, and social activities. Additionally, the dentures or partials should be properly cared for with regular cleaning and by assuring that they continue to fit properly throughout the resident's stay.

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F 278	Continued From page 2	F 278			
F 516 SS=D	<p>Interview with the MDS Corrdinator on 10/11/17 at 12:10 PM in her office revealed she was responsible for completing the dental status section of the MDS for Resident #34. The MDS Cordinator confirmed Resident #34's dental status section on the Quarterly MDS dated 2/7/17, the Annual MDS dated 5/5/17 and the Quarterly MDS dated 8/2/17 were not coded accurately.</p> <p>483.20(f)(5)(i)(ii); 483.70(i)(3) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS</p> <p>483.20(f)(5) Resident-identifiable information.</p> <p>(i) A facility may not release information that is resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to safeguard medical record information against loss or unauthorized use.</p> <p>The findings included:</p> <p>Review of facility policy, Controlled Substance</p>	F 516	<p>1. On 10/10/17 at 4:02 PM the Assistant Director of Nursing secured the controlled substance prescription and educated the licensed nurse on the policy for Controlled Substance Prescriptions emphasizing the importance of maintaining the security of the controlled substance prescriptions by placement of prescriptions into sealed envelopes for delivery to pharmacy. Education was also provide on ensuring the door to the nursing station is locked when licensed staff are not in attendance. The HIPAA Policy was reviewed and the importance of securing resident information including the medical record was stressed with emphasis on always logging off of computers and never leaving a computer work station open when unattended. On 10/10/17 at approximately 4:30 PM an automatic lock was placed on the nursing station door by the Director of Maintenance. On 10/11/17 the maintenance director applied automatic door closure device to the door.</p>		

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F 516	<p>Continued From page 3</p> <p>Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..."</p> <p>Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area.</p> <p>Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.</p>	F 516	<p>2. All residents have the potential to be impacted by this practice. On 10/10/17 at approximately 4:10 PM the Director of Nursing and Assistant Director of Nursing immediately conducted audits of all nursing stations and computers to ensure patient information, medical records, and prescriptions for controlled substances were secured properly. No concerns were identified.</p> <p>3. Facility staff were educated by the Director of Nursing and Assistant Director of Nursing on 10/11/2017 on the HIPAA Policy and the importance of maintaining the confidentiality of resident information including the medical record was reviewed. Logging off of computers and never leaving a computer work station open were emphasized. On 10/11/2017 licensed nurses were educated by the Assistant Director of Nursing and Director of Nursing on the policy for Controlled Substance Prescriptions emphasizing the importance of maintaining the security of the controlled substance prescriptions by placement of prescriptions into sealed envelopes for delivery to pharmacy. Education was also provide on ensuring the door to the nursing station is locked when licensed staff are not in attendance. The HIPAA Policy was reviewed and the importance of securing resident information including the medical record was stressed with emphasis on always logging off of computers and never leaving a computer work station open when unattended. The Director of Nursing or her designee during new Hire Nursing Orientation beginning on 10/25/17 will provide education to nursing staff on the</p>		10.25. 2017

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F 516	<p>Continued From page 3</p> <p>Prescriptions, undated revealed "...In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility: ...Original paper prescription to be placed in a sealed envelope and delivered to pharmacy..."</p> <p>Observation on 10/10/17 at 4:00 PM at the 600 Hall nurses station revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Further observation revealed no facility staff in the nurses station or the immediate area.</p> <p>Observation and interview on 10/10/17 at 4:02 PM at the 600 Hall nurses station, with the Assistant Director of Nursing (ADON) present, revealed the station door open, the desk top computer was logged into a resident's chart and a paper prescription for Lortab was stored on the desk. Interview with the ADON confirmed it was not facility procedure for the computer to be logged on and the paper prescription to be stored on the desk without facility staff present. Further interview confirmed the facility failed to safeguard the medical record information against loss or unauthorized use.</p>	F 516	<p>HIPAA Policy, with emphasis on maintaining security of resident information. Emphasis will be provided regarding security of the medical records, use of privacy screens for computers, logging off of computers and never leaving a computer work station open when unattended. Privacy screen protectors have been ordered for computers and will be applied to computer screens by 10.25.2017 to improve privacy of residents electronic medical records.</p> <p>4. Random audits will be completed by the Director of Nursing, Assistant Director of Nursing and the Manager on Duty on weekends beginning 10/25/17 twice daily for two weeks, then twice weekly for four weeks then weekly for six months, to ensure HIPAA Compliance regarding controlled substance prescriptions, medical record security, use of privacy screens on computers and computers logged off when not in use. Any concerns identified will be reported to the Director of Nursing or designee and addressed immediately with staff reeducation and counseling as appropriate. The results of audits will be forwarded to the Director of Nursing and Administrator for review and follow up then forwarded to the QAPI Committee for review and recommendations.</p>		

THE WATERS OF GALLATIN – In-Service Record

Date:

10/10/17

Subjects covered:

Subjects covered:

- ① Hippa
- ② Controlled Substance Prescriptions
- ③ Nurse station door to be closed & locked when licensed personal not at nurse station

Presented by Christy Nordquist Alden

[illegible]



CONTROLLED SUBSTANCE PRESCRIPTIONS: TN SKILLED NURSING FACILITIES

In compliance with applicable state and federal regulations, and to prevent diversion of controlled substances, the following steps must be taken when a provider completes and signs a prescription for a controlled substance in the skilled nursing facility:

1. If a new or changed therapy, nursing to note the order in patient's paper and/or electronic medical record.
2. Nursing to fax copy of the prescription to pharmacy and document "faxed to pharmacy," along with the date and initials.
3. Nursing to provide a copy for medical records department.
4. Original paper prescription to be placed in a sealed envelope and delivered to pharmacy via

THE WATERS OF GALLATIN - In-Service Record

Date: 10-10-17

Subjects covered:

1. Nippon and Controlled Substance Prescription Policy
2. Training Medical Records
3. Ensuring Computers are closed/locked prior to leaving not in use by staff

PRINT NAME	SIGNATURE	TITLE	SHIFT
Eric Johnson	[Signature]	CMA	6-12
Vicki Litts	[Signature]	RN	7-11
Annette Stewart	[Signature]	CNT	2-10
Amy Carey	[Signature]	CNA	6-2
Sherrie Blackwood	[Signature]	LPN	7-11
Enka Mikkelsen	[Signature]	DPT	Day
Carrie Haapala	[Signature]	OTR/L	Day
Larry Williams	[Signature]	DR	Day
Patricia Roberts	[Signature]	CNT	6-2
STITHAN LITTS	[Signature]	CNA	6-2
Kevin Sallinger	[Signature]	Staff	0-5
Healey Goodtree	[Signature]	CNT	2-10
Seannie Esquivel	[Signature]	D.H.	
Jende Harper	[Signature]	Act	Days
Tony Craig	[Signature]	Main	Days
Jana Dyrum	[Signature]	JOA	
Christy Hoskins	[Signature]	FDON	
Tina Ashworth	[Signature]	BS	Day
Trine Williams	[Signature]	CNA	2-10
Sam Douglas	[Signature]	CNA	8-13
Judy Moore	[Signature]	CNA	6-2
Amy Wright	[Signature]	CNA	6-2
Suey Dyrum	[Signature]	CA	7-7
Jeannette Reynolds	[Signature]	LPN	7-11
Verica Moffett	[Signature]	RN	7-11

THE WATERS OF GALLATIN - In-Service Record

Date: 10-12-17

Subjects covered:

1. Hippa and Controlled substance registration
2. Securing medical records
3. Denying computers are closed / locked prior to leaving work station

PRINT NAME	SIGNATURE	TITLE	SHIFT
Brittany Keith	Brittany Keith	CNA	10-2
Johnia Roberts	Johnia Roberts	CNA	6-2
Seannie Esquivel	Seannie Esquivel	D-HK	
Kim Williams	Kim Williams	CNA	2-10
Scott Douglas	Scott Douglas	ADN	8-4
Vicki Lutz	Vicki Lutz	PA	7A
Sherrie Burkhead	Sherrie Burkhead	LP	7/10
Linda Harper	Linda Harper	ACT	Days
Tammie Vestal	Tammie Vestal	CNA	2-10
Kelsey Gostree	Kelsey Gostree	CNA	2-10
Danette Maner	Danette Maner	ACT	8-5
Kelli Martin	Kelli Martin	CNA	2-10
Monty Williams	Monty Williams	CNA	10-2
Judy Overman	Judy Overman	LDN	7-7
Annette Stewart	Annette Stewart	ENT	2-10
Judy Moore	Judy Moore	CNA	6-2
Amy Wright	Amy Wright	CNA	6-2
Tony Dargatz	Tony Dargatz	meatcare	1st
Garrett Carter	Garrett Carter	Doc	1st
Theresa Walker	Theresa Walker	Lavatory	1-2
Sheila Cantrell	Sheila Cantrell	HGI	
Tierra Adams	Tierra Adams		
Joraleen Olsare	Joraleen Olsare	ACT	6-2
Ruth Gross	Ruth Gross	Doc	
Danette Hall	Danette Hall		
Baron Jones	Baron Jones		
Lola Faulton	Lola Faulton	CNA	6-2
Maria Long	Maria Long		
Richard Moore	Richard Moore		
Sharon Satterfield	Sharon Satterfield	CNA	6-2
Amy Jones	Amy Jones	CNA	6-2
Amanda Wheeler	Amanda Wheeler	CNA	2-10
Danielle Overall	Danielle Overall		
Kayla Pannell	Kayla Pannell	CNA	10-2

THE WATERS OF GALLATIN - In-Service Record

Date: 10-25-17

Subjects covered:

Subjects covered:

- ① CMARS/TARS (make sure all completed and signed off at end shift.)
- ② Admission, Readmission, Discharge, Annual & Six month Assessments completion, Weekly charting
- ③ Skill assessments and documentation. ④ Make sure PIC completed at end CNA shift. Hippa, Securing Medical Records

PRINT NAME	SIGNATURE	TITLE	SHIFT
Jennifer Reynolds	J Reynolds	LPN	7-7
Vickie Little	V Little	RN	7-7
Judy Overman	Judy Overman	LPN	7-7
Merrie Blackwell	Blackwell	LPN	7-7
Nerice Moffitt	Nerice	RN	7a-7p
Ida Newman	Newman	LPN	7-7
Missy Byrd	Byrd	RN	7-7

presented by Christy Hodson ADON

Controlled
Substance
Scripts

presented by Christy Hodgeson Adams